Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

hospital chaplain, he and/or she would have some clinical pastoral education and training to act on the health care environment; he and/or she could record in medical records and participate in clinical rounds. The RS practitioner trained in an interfaith model could respond to universal needs that transcend religion. Care could be offered individually (with privacy and customization to one assisted person at a time) or collectively (small groups of people with common characteristics). Atheists and agnostics may also have generic beliefs and questions about meaning and purpose. The practitioner can act on the grounds of philosophy or by contemplative practices from a nontheistic denomination, such as Buddhism. However, increasing the level of complexity of the case, the care may no long be provided by the practitioner. In such cases, the experience of a community religious minister or the professional chaplain could be fundamental.

In short, the accumulated evidence on the relationship between RS and health allows us to state that this care should be included in a comprehensive health approach. The importance of RS care is too great to depend on isolated institutional initiatives or the availability of a professional health chaplain. Health care insurances and national health systems would have a duty to provide this service alongside other therapies already contemplated. We hope that in the short term this discussion will take place and that health care providers will understand that this is part of their scope.

Marcelo Saad
Spiritist Medical Association
São Paulo, São Paulo, Brazil
E-mail: msaad@uol.com.br

Roberta De Medeiros
Centro Universitário Lusíada
São Paulo, São Paulo, Brazil

https://doi.org/10.1016/j.jpainsymman.2020.09.028

Disclosures and Acknowledgments

This research received no specific funding/grant from any funding agency in the public, commercial, or not-for-profit sectors. The authors declare no conflicts of interest.

References

1. Ferrell BR, Handzo G, Picchi T, Puchalski C, Rosa WE. The urgency of spiritual care: COVID-19 and the critical need for whole-person palliation. J pain symptom Manage 2020;60:e7–e11.

2. Saad M, de Medeiros R. Programs of religious/spiritual support in hospitals - five "whies" and five "hows". Philos Ethics Humanit Med 2016;11:5.

3. WHO. The World health report 2000: health systems: improving performance. ISSN 1020–3311. Geneva, Switzerland. Available from https://www.who.int/whr/2000/en/whr00_en.pdf?ua=1. Accessed August 10, 2020.

4. OECD (Organisation for Economic Cooperation and Development). Proposal for a taxonomy of health insurance. Study on Private Health Insurance. 2004. Available from https://www.oecd.org/health/health-systems/31916207.pdf. Accessed August 10, 2020.

5. Saad M, Daher JC Jr, de Medeiros R. Spirituality, religiousness and physical health: scientific evidence. In: Lucchetti G, Prieto Peres MF, Damiano RF, eds. Spirituality, Religiousness and Health - From Research to Clinical Practice. Switzerland: Springer Publisher, 2019:87–100.

Spiritual Care in the Global Sphere

To the Editor:

We are grateful to Saad and De Medeiros from Brazil for their critically important comments on increased access to spiritual care.[1] They address key issues related to spiritual care delivery, specifically in the global sphere. As Saad and De Medeiros suggest, it is not only spiritual traditions, faiths, and customs that vary significantly by culture and context but also the social dynamics informing how spiritual care is provided in various countries. Coronavirus disease 2019 has called clinicians across specialties and health systems to urgently consider how spiritual care is prioritized, valued, and integrated at generalist and specialist levels to promote whole-person palliation across the life span.[2,3]

High-quality interprofessional spiritual care in the age of pandemic carries substantive implications for spiritual and existential well-being and the effective alleviation of serious health-related suffering, especially at the end of life and during bereavement.[4,5] As the palliative care community continues to advance the importance of spiritual care integration, we should prioritize education for stakeholders and multisector partners accordingly to ensure clear understanding that spirituality encompasses many aspects of a person's inner life. Religiosity is not synonymous with but may be a component of spirituality and spiritual values for many patients. A global consensus-derived inclusive definition of spirituality describes it as a search for meaning, purpose, and transcendence and experience of a relationship to whatever is significant or sacred to a person.[6]

To the point of Saad and De Medeiros, we concur that [a]theists and agnostics may also have … beliefs and questions about meaning and purpose.[1] It is vital to emphasize spiritual care that is individualized for the human spirit at hand, free of labels or categorization. The goal is holistically supportive spiritual

engagement of the person experiencing serious illness, whether they have an identified religious affiliation. Spiritual care that is inclusive, respectful, and honors the recipient as the expert navigator of their personal inner journey is imperative.

In 2014, the World Health Organization called for the strengthening of palliative care as a component of comprehensive care throughout the life course.[7] Repeatedly throughout the document,[7] the World Health Organization acknowledges interprofessional spiritual care as vital to palliative care, in addition to physical and psychosocial care. They note that palliative care—including spiritual care—is an ethical responsibility of all health systems and health professionals.

The Lancet Commission on Global Access to Palliative Care and Pain Relief later focused on quantifying the worldwide burden of serious health-related suffering in terms of physical and psychological symptoms that could be strategically mitigated using an essential package accessible to all, particularly those in low-income and middle-income countries.[8] The commission articulated the importance of not only spiritual care but also the difficulty in measuring and conceptualizing spiritual challenges. Further research will be needed to provide evidence that demonstrates the value of spiritual care as it relates to both outcomes and cost.

Dr. Frank Ostaseski reminds us: In life-transforming moments such as dying … we have a sense of looking into the vast unnamable … Each taste of this experience expands our love and draws us further toward the endless, inexhaustible mystery of being.[9] Of course, such moments are possible not only at the end of life but at an infinite number of points along the illness-wellness spectrum of living and dying. This realization is just one universal concept that is honored through the provision of quality spiritual care beyond boundary, border, and system.

Betty R. Ferrell, RN, PhD, MA, FAAN, FPCN, CHPN
Division of Nursing Research and Education
City of Hope National Medical Center
Duarte, California, USA
E-mail: bferrell@coh.org

George Handzo, MDiv, APBCC
Health Services Research & Quality
HealthCare Chaplaincy Network
New York, New York, USA

Tina Picchi, MA, BCC
Cambia Health Foundation Sojourns Scholar Mentor
Camarillo, California, USA

Christina Puchalski, MD, OCDS, FAAHPM, FACP
Medicine and Health Sciences
The George Washington University's Institute for Spirituality and Health
The George Washington University School of Medicine and Health Sciences
Washington, District of Columbia, USA

William E. Rosa, PhD, MBE, ACHPN, FAANP, FAAN
Psycho-Oncology
Department of Psychiatry and Behavioral Sciences
Memorial Sloan Kettering Cancer Center
New York, New York, USA

https://doi.org/10.1016/j.jpainsymman.2020.09.031

Disclosures and Acknowledgments

This research received no specific funding/grant from any funding agency in the public, commercial, or not-for-profit sectors. The authors declare no conflicts of interest.

References

1. Saad M, De Medeiros R. Should spiritual care be covered by healthcare insurance and health systems? J Pain Symptom Manage 2020;60:e36–e37.

2. Ferrell BR, Handzo G, Picchi T, Puchalski C, Rosa WE. The urgency of spiritual care: COVID-19 and the critical need for whole-person palliation. J Pain Symptom Manage 2020;60:e7–e11.

3. Puchalski C, Bauer R, Ferrell B, et al. Interprofessional spiritual care in the time of COVID-19 – briefing note. Global palliative care and COVID-19 series. Available from http://globalpalliativecare.org/covid-19/uploads/briefing-notes/briefing-note-interprofessional-spiritual-care-in-the-time-of-covid-19.pdf. Accessed September 4, 2020.

4. Emanuel L, Solomon S, Fitchett G, et al. Fostering existential maturity to manage terror in a pandemic. [Epub ahead of print]. J Palliat Med 2020; https://doi.org/10.1089/jpm.2020.0263.

5. Rosa WE, Ferrell BR, Applebaum AJ. The alleviation of suffering during the COVID-19 pandemic. [Epub ahead of print]. Palliat Support Care 2020;1–3. https://doi.org/10.1017/S1478951520000462.

6. Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the spiritual dimension of whole person care: reaching national and international consensus. J Palliat Med 2014;17:642–656.

7. World Health Organization. WHA resolution 67.19: strengthening of palliative care as a component of comprehensive care throughout the life course. 2014. Available from https://apps.who.int/gb/ebwha/pdf_files/EB134/B134_28-en.pdf. Accessed September 4, 2020.

8. Knaul FM, Farmer PE, Krakauer EL, et al. Alleviating the access abyss in palliative care and pain relief-an imperative of universal health coverage: the Lancet Commission report. Lancet 2018;391:1391–1454.

9. Ostaseksi F. The Five Invitations: Discovering What Death Can Teach Us About Living Fully. New York: Flatiron Books, 2017.